A chest pain clinic run by specifically trained staff offers rapid assessment of patients with suspected cardiac symptoms of recent onset and allows early investigation and intervention if appropriate. However, such a facility has important consequences for hospital resources in terms of bed availability and the workload of the cardiac catheterisation laboratory.

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Comment

We all can cite cases where a patient complaining of chest pain had a normal electrocardiogram in Accident and Emergency and was discharged with tragic consequences. Norell *et al* found that 43 of 109 patients with recent onset of chest pain and a normal electrocardiogram subsequently had an unequivocal clinical diagnosis of cardiac pain. In nearly all of them (41) this diagnosis was confirmed at coronary angiography. Subsequently 26—nearly a quarter—of the original group with a normal electrocardiogram had coronary angioplasty or coronary artery surgery. This shows that we must not rely on a normal electrocardiogram to exclude important coronary disease in patients with recent onset of chest pain. Ideally, if resources permit, these patients should be assessed later by exercise testing.

Norell and his colleagues have given us a useful measure of the true size of this potentially dangerous problem. The message is not new to cardiologists but now that we see the size of the problem we must alert general practitioners, general physicians, and junior doctors in casualty departments and remind them that the electrocardiogram and patient should always be examined together.

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